General

Guideline Title

Problem drinking.

Bibliographic Source(s)

Medical Services Commission. Problem drinking. Victoria (BC): British Columbia Medical Services Commission; 2011 Apr 1. Various p. [36 references]

Guideline Status

This is the current release of the guideline.

Recommendations

Major Recommendations

Problem Drinking Part 1 - Screening and Assessment

Screening and Assessment

Screening identifies patients who need further assessment or treatment by determining their level of risk based on reported alcohol use and other relevant clinical information. Consider the following two screening questions during any patient interaction, when clinical triggers/red flags (see the table below) are observed and/or when a patient fails to respond to appropriate management (see *Screening - Asking About Alcohol Use* algorithm in original guideline document).

Q1. Do you sometimes drink beer, wine or other alcoholic beverages?

Q2. How many times in the past year have you had:

- 5 or more drinks in one day (men)?
- 4 or more drinks in one day (women)?

Practitioners may wish to use the "Alcohol Screening Note" provided in the original guideline document.

Interventions should be selected based on the assessment completed during the screening. Although alcohol misuse is a spectrum disorder, positive screens will fall into one of three categories:

1. At-risk drinking:
    - Men - 5 or more drinks on one or more days in the last year.

- Women - 4 or more drinks on one or more days in the last year.

2. Alcohol abuse: Patient meets 1 or more Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV) criteria for abuse in the last 12 months.
3. Alcohol dependence: Patient meets 3 or more DSM IV criteria for dependence in the last 12 months.

Table: Clinical Triggers/Red Flags

Medical	Mental	Psycho-social
• MCV >96 • Elevated GGT, AST, ALT (especially a GGT or AST:ALT >2:1) • GERD, hypertension, diabetes, pancreatitis • Chronic non-cancer pain • Alcohol on breath	• Cognitive impairment or decline • Mood, anxiety or sleep disorder • Significant behavioural or academic change	• Unexplained time off work/loss of employment • Frequent no show for appointments • Poor medication compliance • Significant life event (e.g., divorce, loss of spouse, parent) • Recent or recurrent trauma or domestic violence • High-risk behaviours (problem gambling, DUI, STIs)

ALT, alanine transaminase; AST, aspartate aminotransferase; DUI, driving under the influence; GERD, gastroesophageal reflux disease; GGT, gamma-glutamyl transpeptidase; MCV, mean corpuscular volume; STIs, sexually transmitted infections

Note: Laboratory evaluation, including liver function tests, are not necessary unless clinically indicated and are not sensitive enough to be used alone as screening tests.

AUDIT, CAGE and CRAFFT Tests

- AUDIT: The Alcohol Use Disorders Identification Test (AUDIT), a 10 item questionnaire, can identify at-risk or problem drinking as well as dependence. The test can be used as a re-assessment tool by repeating it at a later time.
- CAGE: The CAGE questionnaire is a less sensitive tool at detecting alcohol abuse. This test can be used in addition to the screening provided in this guideline. However for primary screening it is recommended physicians use the two-question screen first.
- CRAFFT: The CRAFFT screen is specifically designed for use in adolescents.

Assessment

- The following tables provide the DSM IV criteria and sample questions for determining alcohol abuse or dependence.
- Questions correspond with alcohol screening note criteria for abuse or dependence.
- First assess for alcohol abuse, then, if indicated, assess for dependence (see the tables below).

General Questions

One of the following introductory questions can be used before asking about abuse or dependence:

- Q. Has your life ever been affected by alcohol?
- Q. Has your spouse or anyone said anything about your drinking?
- Q. How long have you been drinking like this?

Table: Questions and Criteria for Assessing Abuse

In the past 12 months, has the patient's drinking caused or contributed to -	Sample Questions
A1. Role failure	Q. Have you missed work or class because of your drinking?
A2. Risk of bodily harm	Q. Do you sometimes drink and drive?

In the past 12 months, has the patient's drinking caused or contributed to -	Sample Questions
A3. Run-ins with the law/legal issues	Q. Have you been charged with Driving Under the Influence (DUI) or been given a road side suspension?
A4. Relationship trouble	Q. Has your spouse or family complained about your drinking?
Conclusion -	Yes ≥1 --- your patient has alcohol abuse. Proceed to the questions in the table below. No --- proceed to Part 2 - Brief Intervention for At-Risk Drinking.

Table: Questions and Criteria for Assessing Dependence

In the past 12 months, the patient has -	Sample Questions
D1. Increased tolerance	Q. Do you need to drink more to get the same effect?
D2. Experienced withdrawal	Q. When you stop drinking, have you ever experienced physical or emotional withdrawal? Have you had any of the following symptoms: irritability, anxiety, shakes, sweats, nausea, or vomiting?
D3. Failed to stick to drinking limits	Q. Do you often drink more than you plan to?
D4. Failed attempts to cut down or stop drinking	Q. Have you ever tried to cut down or stop drinking? How long did that last?
D5. Spent a lot of time on drinking related activities	Q. Do you spend more time thinking about or recovering from alcohol than you used to? Have you ever thought of ways to avoid getting caught?
D6. Spent less time on other matters	Q. Have you reduced family or recreational events because of alcohol use in the past year?
D7. Kept drinking despite psychological or physical problems	Q. Do you think that drinking is causing problems for you? What keeps you drinking?
Conclusion -	Yes ≥3 --- your patient has alcohol dependence. Proceed to Part 2 - Brief Intervention for Alcohol Dependence. No --- your patient still has alcohol abuse. Proceed to Part 2 - Brief Intervention for Alcohol Abuse.

Problem Drinking Part 2 - Brief Intervention

Note: If a patient is being seen for another problem, it may be necessary for screening to be done at the first appointment and intervention done at a follow up appointment.

Selected interventions should be based on the assessment completed during the screening (see "Problem Drinking Part 1 - Screening and Assessment" recommendations above). Although alcohol misuse is a spectrum disorder, positive screens will fall into one of three categories indicated above (at-risk drinking, alcohol abuse, alcohol dependence).

Practitioners may wish to use the "Brief Intervention Follow-up Note" provided with the guideline.

Intervention for Alcohol Abuse (See also the "Brief Intervention for At-Risk Drinking [No Abuse or Dependence]" algorithm in the original guideline document.)

Physicians are advised to take the following steps when conducting an intervention:

1. State your conclusion and recommendation clearly:
    - "I believe that you have an alcohol use disorder. I strongly recommend that you stop drinking and I'm willing to help."
    - Relate to the patient's concerns and medical findings if present.
2. Negotiate a goal and develop a plan:
    - Abstaining is the safest course for most patients with alcohol use disorders.

- Patients who have milder forms of abuse or dependence and are unwilling to abstain may be successful at cutting down.

3. Consider referring to external or community resources:
    - Alcohol and drug counselor, addiction medicine physician.
    - Community groups such as AA (Alcoholics Anonymous).
    - See CHARD (Community Health and Resource Directory).

For abuse: If patient will not abstain, advise cutting down to established drinking limits. Provide follow-up and support.

Intervention for Alcohol Dependence

For dependence, complete the following in addition to steps 1-3 above:

4. For patients who have dependence:
    - Monitor for withdrawal - 15% to 20% of alcohol dependent drinkers require inpatient withdrawal. Refer to "Problem Drinking Part 3 - Office Based Management of Alcohol Withdrawal and Prescribing Medications for Alcohol Dependence" below.
5. Prescribing Medications for Alcohol Dependence
   Medication, in conjunction with psychosocial interventions, can play a valuable part in the management of alcohol dependence. See "Problem Drinking Part 3 - Office Based Management of Alcohol Withdrawal and Prescribing Medications for Alcohol Dependence" below for more information on prescribing medications.

6. Arrange followup appointments, including medication management support if needed. See "Problem Drinking Part 3 - Office Based Management of Alcohol Withdrawal and Prescribing Medications for Alcohol Dependence" below. To support behaviour change, consider seeing patient at least once every 14 days in initial period.

For dependence: Advise abstinence with medication support.

Follow-up and Support (see the "Followup and Support" algorithm in the original guideline document)

REMINDER: Document alcohol use and review goals at each visit (use the "Brief Intervention Follow-up Note" in the original guideline document). If the patient is receiving a medication for alcohol dependence, medication management support should be provided.

Problem Drinking Part 3 - Office Based Management of Alcohol Withdrawal and Prescribing Medications for Alcohol Dependence

Office Based Management of Alcohol Withdrawal

Contraindications to outpatient alcohol withdrawal management:

- History of withdrawal seizure or withdrawal delirium.
- Multiple failed attempts at outpatient withdrawal.
- Unstable associated medical conditions: coronary artery disease (CAD), insulin-dependent diabetes mellitus (IDDM).
- Unstable psychiatric disorders: psychosis, suicidal ideation, cognitive deficits, delusions or hallucinations.
- Additional sedative dependence syndromes (benzodiazepines, gamma-hydroxy butyric acid, barbiturates and opiates).
- Signs of liver compromise (e.g., jaundice, ascites).
- Failure to respond to medications after 24-48 hours.
- Pregnancy.
- Advanced withdrawal state (delirium, hallucinations, temperature >38.5°).
- Lack of a safe, stable, substance-free setting and care giver to dispense medications.

Benzodiazepines are considered the treatment of choice for the management of alcohol withdrawal symptoms. Benzodiazepines reduce the signs and symptoms of alcohol withdrawal, incidence of delirium, and seizures. Based on indirect comparisons there is currently no strong evidence that particular benzodiazepines are more effective than others and selection should be made on an individual basis. Alprazolam and triazolam are not recommended.

Diazepam (Valium®) is recommended due to its efficacy profile, wide therapeutic window and "self tapering" effect due to its long half life. Other benzodiazepines can be considered such as: clonazepam, lorazepam and oxazepam. In the case of intolerance to benzodiazepines, physicians may wish to consider using a different class of medications (i.e., anticonvulsants). It is recommended that physicians with less experience with diazepam follow the rigid schedule. Physicians with experience using diazepam for alcohol withdrawal can consider front loading. Three medication protocols are provided (see the table *Treating Alcohol Withdrawal With Diazepam [Valium]* in the original guideline document).

When conducting outpatient withdrawal, do the following:

- Start on a Monday or Tuesday unless weekend coverage is available.
- See the patient daily for the first three to four days and be available for phone contact.
- Have the patient brought to the office by a reliable family member or caregiver.
- Prescribe thiamine (vitamin B_1) 100 mg daily for five days.
- Encourage fluids with electrolytes, mild foods and minimal exercise.
- Avoid natural remedies, caffeine or any activity that increases sweating (e.g., hot baths, showers and saunas/sweat lodges).
- Assess vital signs, withdrawal symptoms, hydration, emotional status, orientation, general physical condition and sleep at each visit.
- Encourage patient to call local (including health authority/municipal) Alcohol and Drug or Employee Assistance Programs and attend AA meeting on day 3.
- Monitor for relapse, explore cause, and correct if possible. If unable to address cause, refer to inpatient detoxification.

Prescribing Medications for Alcohol Dependence

Three medications are currently available:

- Naltrexone*: Blocks euphoria associated with alcohol use. Contraindicated in patients taking opiates.
- Acamprosate*: Reduces chronic withdrawal symptoms.
- Disulfiram: Adversive agent, causes nausea, vomiting, dysphoria with alcohol use and requires abstinence and counseling before initiation. Disulfiram should be used with caution.

*Not covered, product(s) are under review.

Why Should Medications Be Considered for Treating an Alcohol Use Disorder?

Consider pharmacotherapy for all patients with alcohol dependency. Patients who fail to respond to psychosocial approaches and/or addiction counselling are particularly strong candidates. The above medications can be used immediately following withdrawal or any time thereafter; however, these medications should be used in conjunction with addiction counselling and other psychosocial supports.

Must Patients Agree to Abstain?

No matter which alcohol dependence medication is used, patients who have a goal of abstinence, or who can abstain even for a few days prior to starting the medication, are likely to have better outcomes. Still, it is best to determine individual goals with each patient. Some patients may not be willing to endorse abstinence as a goal, especially at first. However, abstinence remains the optimal outcome.

A patient's willingness to abstain has important implications for the choice of medication. For example, a study of oral naltrexone demonstrated a modest reduction in the risk of heavy drinking in people with mild dependence who chose to cut down rather than abstain. Acamprosate is approved for use in patients who are abstinent at the start of treatment. Total abstinence is needed with disulfiram. Disulfiram is contraindicated in patients who continue to drink, because a disulfiram-alcohol reaction occurs with any alcohol intake.

Which of the Medications Should Be Prescribed? (See Appendix A: "Prescription Medication Table for Alcohol Dependence" in Part 3 of the original guideline document)

Which medication to use will depend on clinical judgment and patient preference. Each has a different mechanism of action. Some patients may respond better to one type of medication than another.

Naltrexone

Naltrexone works by blocking the euphoria associated with alcohol use. Its use is contraindicated in patients taking opiates. Oral naltrexone is associated with lower percentage drinking days, fewer drinks per drinking day, and longer times to relapse. It is most effective in patients with strong cravings. Efficacy beyond 12 weeks has not been established. Although it is especially helpful for curbing consumption in patients who have drinking "slips" it may also be considered in patients who are motivated, have intense cravings and are not using or going to be using opioids. It appears to be less effective in maintenance of abstinence as meta-analyses have shown variable results. Monitoring of liver enzymes may be required.

Acamprosate

Acamprosate works by reducing chronic withdrawal symptoms. Acamprosate increases the proportion of dependent drinkers who maintain abstinence for several weeks to months, a result demonstrated in multiple European studies and confirmed by a meta-analysis of 17 clinical trials. However, this has not been demonstrated in patients who have not undergone detoxification and not achieved alcohol abstinence prior to beginning

treatment. Acamprosate should be initiated as soon as possible after detoxification and the recommended duration of treatment is one year. There is currently insufficient evidence to suggest that acamprosate has a therapeutic advantage over naltrexone.

Disulfiram

Disulfiram is an adversive agent that causes nausea, vomiting, and dysphoria with alcohol use. Abstinence and counselling are required before initiation of treatment with disulfiram. Data on the effectiveness of disulfiram in alcohol use disorders is mixed. Disulfiram has been shown to have modest effects on maintaining abstinence from alcohol, particularly if it is administered under supervision. It is most effective when given in a monitored fashion, such as in a clinic or by a spouse. Thus the utility and effectiveness of disulfiram may be considered limited because compliance is generally poor when patients are given it to take at their own discretion. Disulfiram may be considered for those patients that can achieve initial abstinence, are committed to maintaining abstinence, can understand the consequences of drinking alcohol while on disulfiram, and can receive adequate ongoing supervision. It may also be used episodically for high-risk situations, such as social occasions where alcohol is present. Daily uninterrupted disulfiram therapy should be continued until full patient recovery, which may require months to years.

How Long Should Medications Be Maintained?

The risk for relapse to alcohol dependence is very high in the first 6 to 12 months after initiating abstinence and gradually diminishes over several years. Therefore, a minimum initial period of 6 months of pharmacotherapy is recommended. Although an optimal treatment duration hasn't been established, treatment can continue for one to two years if the patient responds to medication during this time when the risk of relapse is highest. After patients discontinue medications, they may need to be followed more closely and have pharmacotherapy reinstated if relapse occurs.

If One Medication Does Not Work, Should Another Be Prescribed?

If there is no response to the first medication selected, you may wish to consider a second. This sequential approach appears to be common clinical practice, but currently there are no published studies examining its effectiveness. There is not enough evidence to recommend a specific ordering of medications.

Is There Any Benefit to Combining Medications?

There is no evidence that combining any of the medications to treat alcohol dependence improves outcomes over using any one medication alone.

Should Patients Receiving Medications Also Receive Specialized Alcohol Counselling or a Referral to Mutual Help Groups?

Offering the full range of effective treatments will maximize patient choice and outcomes, since no single approach is universally successful or appealing to patients. Medications for alcohol dependence, professional counselling, and mutual help groups are part of a comprehensive approach. These approaches share the same goal while addressing different aspects of alcohol dependence: neurobiological, psychological, and social. The medications are not prone to abuse, so they do not pose a conflict with other support strategies that emphasize abstinence. Using medications to treat patients does not interfere with counselling or other abstinence based programs such as AA.

Almost all studies of medications for alcohol dependence have included some type of counselling, and it is recommended that all patients taking these medications receive at least brief medical counselling. In a recent large trial, the combination of oral naltrexone and brief medical counselling sessions delivered by a nurse or physician was effective without additional behavioral treatment by a specialist. Patients were also encouraged to attend mutual support groups to increase social encouragement for abstinence.

Clinical Algorithm(s)

The following clinical algorithms are provided in the original guideline document:

- Screening - Asking About Alcohol Use
- Brief Intervention For At-Risk Drinking (no abuse or dependence)
- Follow up and Support

Scope

Disease/Condition(s)

- Problem drinking
- Alcohol abuse
- Alcohol dependence

Guideline Category

Counseling

Diagnosis

Evaluation

Management

Risk Assessment

Screening

Treatment

Clinical Specialty

Family Practice

Internal Medicine

Intended Users

Advanced Practice Nurses

Health Care Providers

Nurses

Physician Assistants

Physicians

Public Health Departments

Substance Use Disorders Treatment Providers

Guideline Objective(s)

To provide practitioners with practical information on how to:

- Conduct screening for problem drinking in adults
- Conduct brief intervention for problem drinking in adults
- Conduct office based management of withdrawal and medication management for adult (19+) patients with alcohol dependence

Target Population

Adults 19 years of age or older

Note: Although this document does not deal specifically with teenagers, screening for this age group is also recommended.

Interventions and Practices Considered

Screening/Assessment

1. Two-question screening or more extensive screening questionnaires
2. Assessment of medical, mental, and psychosocial flags and triggers
3. Assessment of risk category (at-risk, abuse, dependence)
4. Frequency of rescreening

Treatment/Management/Counseling

1. Statement of assessment conclusions
2. Goal setting and planning to reach goal
3. Referral to external or community resources
4. Monitoring for withdrawal
5. Prescription medications to treat dependence (benzodiazepines)*
6. Psychosocial interventions
7. Follow-up and support

*Alprazolam and triazolam were not recommended for substance abuse treatment.

Major Outcomes Considered

- Efficacy of screening tools and interventions
- Change in alcohol and other drug use
- Change in frequency and cost of acute care use
- Rate of motor vehicle crashes
- Rate of arrests for alcohol or other substance violations
- Rate of comorbidities with alcohol consumption problems
- Rate of successful outpatient alcohol withdrawal management

Methodology

Methods Used to Collect/Select the Evidence

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

Evidence was obtained through a systematic review of peer-reviewed literature (up to April 2011) using the databases MEDLINE, PubMed, EBSCO, Ovid, and the Cochrane Collaboration's Database for Systematic Reviews. Clinical practice guidelines from other jurisdictions for problem drinking, alcohol dependence, substance use, addiction and substance dependency screening were also reviewed.

Number of Source Documents

Not stated

Methods Used to Assess the Quality and Strength of the Evidence

Not stated

Rating Scheme for the Strength of the Evidence

Not applicable

Methods Used to Analyze the Evidence

Review of Published Meta-Analyses

Systematic Review

Description of the Methods Used to Analyze the Evidence

Not stated

Methods Used to Formulate the Recommendations

Expert Consensus

Description of Methods Used to Formulate the Recommendations

This guideline is an evidence based clinical guideline for general practitioners with consensus statements when evidence is not available. It is based on scientific evidence current as of the Effective Date.

Rating Scheme for the Strength of the Recommendations

Not applicable

Cost Analysis

- Screening, Brief Intervention and Referral to Treatment (SBIRT) can cut hospitalization costs by $1,000 per person screened and save $4 for every $1 invested in trauma center and emergency department screening.
- Outpatient alcohol withdrawal is safe and cost effective for the vast majority of problem drinkers.

Method of Guideline Validation

External Peer Review

Internal Peer Review

Description of Method of Guideline Validation

The guideline was approved by the British Columbia Medical Association and adopted by the Medical Services Commission.

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

This guideline is an evidence based clinical guideline for general practitioners with consensus statements when evidence is not available. They type of evidence supporting the recommendations is not specifically stated.

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

- Appropriate screening, assessment and brief intervention of patients with problem drinking
- Appropriate management and treatment of patient with alcohol abuse or dependence

Potential Harms

Side effects of medications (see Appendix A in Part 3 of the original guideline document for side effects and interactions of specific medications)

Contraindications

Contraindications

Contraindications to Outpatient Alcohol Withdrawal Management

- History of withdrawal seizure or withdrawal delirium.
- Multiple failed attempts at outpatient withdrawal.
- Unstable associated medical conditions: coronary artery disease (CAD), insulin-dependent diabetes mellitus (IDDM).
- Unstable psychiatric disorders: psychosis, suicidal ideation, cognitive deficits, delusions or hallucinations.
- Additional sedative dependence syndromes (benzodiazepines, gamma-hydroxy butyric acid, barbiturates and opiates).
- Signs of liver compromise (e.g., jaundice, ascites).
- Failure to respond to medications after 24-48 hours.
- Pregnancy.
- Advanced withdrawal state (delirium, hallucinations, temperature >38.5°).
- Lack of a safe, stable, substance-free setting and care giver to dispense medications.
- History of withdrawal seizure or withdrawal delirium.

Medication Contraindications

- Naltrexone* is contraindicated in patients taking opiates.
- Disulfiram is contraindicated in patients who continue to drink, because a disulfiram-alcohol reaction occurs with any alcohol intake.
- See Appendix A in Part 3 of the original guideline document for additional contraindications.

Qualifying Statements

Qualifying Statements

The Clinical Practice Guidelines (the "Guidelines") have been developed by the Guidelines and Protocols Advisory Committee on behalf of the Medical Services Commission. The Guidelines are intended to give an understanding of a clinical problem, and outline one or more preferred approaches to the investigation and management of the problem. The Guidelines are not intended as a substitute for the advice or professional judgment of a health care professional, nor are they intended to be the only approach to the management of clinical problems.

Implementation of the Guideline

Description of Implementation Strategy

An implementation strategy was not provided.

Implementation Tools

Chart Documentation/Checklists/Forms

Clinical Algorithm

Mobile Device Resources

Resources

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Getting Better

Staying Healthy

IOM Domain

Effectiveness

Patient-centeredness

Identifying Information and Availability

Bibliographic Source(s)

Medical Services Commission. Problem drinking. Victoria (BC): British Columbia Medical Services Commission; 2011 Apr 1. Various p. [36 references]

Adaptation

Significant portions of this guideline were adapted from the National Institute on Alcohol Abuse and Alcoholism (NIAAA), "Helping Patients Who Drink Too Much", A Clinicians' Guide, Updated 2005 Edition. A full copy of the guideline and reference materials can be found on the NIAAA Web site .

Date Released

2011 Apr 1

Guideline Developer(s)

Medical Services Commission, British Columbia - State/Local Government Agency [Non-U.S.]

Source(s) of Funding

Medical Services Commission, British Columbia

Guideline Committee

Guidelines and Protocols Advisory Committee

Composition of Group That Authored the Guideline

Not stated

Financial Disclosures/Conflicts of Interest

Not stated

Guideline Status

This is the current release of the guideline.

Guideline Availability

Electronic copies: Available from the British Columbia Ministry of Health Web site .

The guideline is also available for mobile devices from the British Columbia Ministry of Health Web site .

Availability of Companion Documents

An alcohol screening note, a brief intervention follow-up note, and standard drink size illustrations are available in the original guideline document .

Patient Resources

None available

NGC Status

This NGC summary was completed by ECRI Institute on January 31, 2013. The information was verified by the guideline developer on March 20, 2013.

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